DEPARTMENT OF Managed Health Care Help Center

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

CIGNA DENTAL HEALTH OF CALIFORNIA, INC.

A DENTAL HEALTH PLAN

DATE ISSUED TO PLAN: JUNE 23, 2015
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Final Report of a Routine Survey
Cigna Dental Health of California, Inc.
A Dental Health Plan
June 23, 2015

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EXECUTIVE SUMMARY

On April 24, 2013, the California Department of Managed Health Care (the "Department") notified Cigna Dental Health (the "Plan") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from August 27, 2013 through August 29, 2013. The Department completed its investigatory phase and closed the survey on November 25, 2013.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Language Assistance

The Department identified **four** deficiencies during the current Routine Survey. The 2013 Survey Deficiencies table below notes the status of each deficiency.

2013 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
QUALITY MANAGEMENT		
#1	**The Plan does not ensure the governing body oversees their Quality Management Program responsibilities, including review of the actions and findings of the Quality Management Committee.** Section 1363.5(b); Sections 1367.01(a), (b) and (f); Rule 1300.70 (b)(2)(C)	**Not Corrected**
#2	**The Plan does not ensure that the membership of its Public Policy Committee includes at least 51% enrollees.** Rule 1300.69(a)	**Not Corrected**
GRIEVANCES AND APPEALS		
#3	**The Plan fails to identify and process all grievances in accord with all the requirements under the law.** Section 1368(a)(1); Section 1386(b)(1); Rules 1300.68(b)(1) and(5); and Rules 1300.68(d)(1) and (3)	**Not Corrected**
UTILIZATION MANAGEMENT		
#4	**The Plan does not have a documented quality assurance process that assesses and evaluates compliance with utilization management requirements under Section 1367.01.** Section 1367.01(j)	**Not Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Survey of a Plan that covers major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Preliminary Report was issued to the Plan on April 1, 2015. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on April 24, 2013 and closed on November 25, 2013.

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

PLAN BACKGROUND

Cigna Dental Health of California, Inc. ("Cigna Dental") is a for-profit California corporation incorporated on October 23, 1985. It is a wholly owned subsidiary of Cigna Dental Health, Inc., whose parent company is Cigna Corporation. Cigna Dental received a license as a specialized health care service plan from the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 on March 11, 1986.

As of May 2, 2012, Cigna Dental had 197,326 members and 2,144 primary care facilities. The Plan had 3,331 unique dentists spread across 8,523 listed access points. Additionally, the Plan had 1,539 specialists spread across 7,338 listed access points.

Cigna Dental delegates credentialing of associate dentists at both Western Dental Services, Inc. and The CDI Group, formerly known as Coastal Dental.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On April 1, 2015, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

(a) Develop and implement a corrective action plan for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY MANAGEMENT

Deficiency #1: The Plan does not ensure the governing body oversees their Quality Management Program responsibilities, including review of the actions and findings of the Quality Management Committee.

Statutory/Regulatory Reference(s): Section 1363.5(b); Sections 1367.01(a), (b) and (f); Rule 1300.70(b)(2)(C)

Assessment: Pre-onsite review of the Plan's document, 2013 California QMP Document revealed the Plan intended to present Quality Management Program Activities to the Board of Directors twice in 2013. Review of the Board of Directors Meeting Minutes revealed that during the years 2010 through 2013, the Quality Management Program, the Utilization Management Program, and associated Work Plans for each of these programs were not presented to the Board of Directors for review and approval until June of 2013. The Plan's document, QM Reporting and Analysis Cover states, "The Plan's Quality Management Program ("QMP") activities are reported to the Board of Directors on a yearly basis utilizing the report, *"Quality Management Program Metrics, California"*. However, Rule 1300.70(b)(2)(C) requires:

> The plan's *governing body*, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, *shall* each *meet* on a *quarterly basis*, or more frequently if problems have been identified, *to oversee their respective QA program responsibilities*. . . . Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues. [Emphasis added.]

Additionally, Section 1363.5 requires:

> A plan *shall disclose* or provide for the disclosure *to the director* . . . the process the plan . . . uses to authorize, modify, or deny health care services under the benefits provided by the plan . . . The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01. [Emphasis added.]

Section 1363.5(b) and Sections 1367.01(a), (b) and (f) require that the Plan conduct an annual evaluation of the Utilization Management Program, including utilization management criteria and related policies and procedures, including a description of the process by which the Plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees. Further, Section 1363.5(b) and Sections 1367.01(a), (b) and (f) require the Plan to file these documents with the Department for review and approval. The Plan's policy, Utilization Review Standard Operating Procedure states:

> Utilization Review is a case-by-case determination as to whether dental services that have been provided or are proposed to be provided to a covered person are necessary and appropriate to the patient's oral health based upon accepted dental practices. This Standard Operating Procedure will be (at minimal) *reviewed annually, and re-filed with the Department of Managed Health Care ("Department"), upon revision.* [Emphasis added.]

This policy indicates an effective date of January 1, 2000, with revisions made on January 15, 2007 and January 15, 2010. Comparison of this policy with the same document submitted by the Plan during the 2010 Routine Survey also reveal the version submitted for the 2013 Routine Survey has been revised from the previous version. The Department is unable to confirm this policy has been filed with the Department for review as required by this policy and Section 1363.5.

The Department found the Plan did not comply with Rule 1300.70(b)(2)(C) or Sections 1363.5(b) and 1367.01(a), (b) and (f), or with its own policy regarding annual review and approval of the Quality Management and Utilization Management Programs, or the respective Work Plans by the Board of Directors. These documents were updated and implemented, but they were not formally submitted for review and approval by the Board annually. The Plan is also not compliant with the requirements of Section 1363.5 for not filing the utilization management documents with the Department for review and approval.

The Department finds the Plan to be out of compliance with Rule 1300.70(b)(2)(C), Section 1363.5(b) and Sections 1367.01(a), (b) and (f) due to the lack of quarterly Quality Management meetings and the absence of annual review, evaluation and approval of its Programs, Work Plans, and criteria, and for not filing their program documents with the Department.

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: In March of 2014, the Plan updated the bylaws of Cigna Dental Health of California, Inc. to reflect the requirement the Board of Directors meet on a quarterly basis. The revised bylaws were filed[2] with the Department's Office of Plan Licensing for review and received approval in April of 2014. The Plan's response to this deficiency also stated:

> [T]he Plan will ensure that the Quality Compliance Manager for Cigna Dental Health of California, Inc. is present at the Board of Director[s] meetings to present all actions and findings of the Quality Management Committee for review. This review will also include an annual review of the Plan's "Utilization Review Policy" as required by Sections 1363.5(b) and 1367.01(a), (b) and (f).
>
> The Plan has implemented internal mechanisms to ensure that the "Utilization Review Policy" will be filed with the Department following any updates.

Final Report Deficiency Status: Not Corrected

The Plan did not submit any Board of Directors' meeting minutes to validate any presentations made to the Board related to the actions and findings of the Quality Management Committee. The Department finds that while the Plan has made changes to the Plan's bylaws to require quarterly meetings of the Board of Directors, as well as stated that the Plan will ensure presentation to the Board by the Quality Compliance Manager of the actions and findings of the Quality Management Committee for Board review and approval, the Plan has not demonstrated that all these changes have been implemented.

The Department will review the Board of Directors' meeting minutes during the Follow-Up Survey to confirm if all the specified actions and process changes have been implemented. The Department will also review any utilization management documents filed with the Department's Office of Plan Licensing to confirm that the Plan has filed the Utilization Review Policy for Department approval when updates are made, as required by Section 1367.01(b).

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

Deficiency #2: The Plan does not ensure that the membership of its Public Policy Committee includes at least 51% enrollees.

[2] Filing #20140822

Statutory/Regulatory Reference(s): Rule 1300.69(a)(2)(A)

Assessment: The Department's review of Plan documents and onsite interviews with the Plan staff revealed that the Public Policy Committee is not comprised of at least 51% enrollees. There is only one member identified as an enrollee on the committee. During onsite interviews, the Regional Dental Director stated that they were aware of the deficiency and were working towards correcting this issue. Review of Plan documents, including the Public Policy Committee Meeting Minutes, indicates the Plan was non-compliant for over a year with the requirement of Rule 1300.69(a)(2)(A) regarding Public Policy Committee membership consisting of at least 51% enrollees. The Plan stated that the reason for its non-compliance was that it had had difficulties recruiting enrollees to participate on the Public Policy Committee.

Rule 1300.69(a)(2)(A) requires the Plan to maintain a Public Policy Committee with 51% of the members comprised of enrollees, or to ensure enrollee participation at the Governing Board level. The Plan is non-complaint with this requirement, therefore the Department finds the Plan to be non-compliant with Rule 1300.69(a)(2)(A).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan has recently updated the bylaws of Cigna Dental Health of California, Inc. to change the composition of the Board of Directors to three (3) members, including an enrollee, as allowed by Rule 1300.60(a)(1), in lieu of a Public Policy Committee. The Plan also updated the bylaws to remove the requirement the Plan have a Public Policy Committee. This change to the bylaws was filed[3] with the Department's Office of Plan Licensing for review, and received approval prior to the close of the investigatory phase of this routine survey. The Plan's response to this deficiency also stated:

> The Plan will be implementing the change in composition to the Board of Directors and elect an enrollee member during its next regularly scheduled meeting in June 2015. Furthermore, the Plan will file the change in officers with the Department.

Final Report Deficiency Status: Not Corrected

The Department finds that while the Plan has made changes to the Plan's bylaws to dissolve the Public Policy Committee required by Rule 1300.69(a)(2)(A), and change the Board of Directors' composition to ensure at least one-third of the Board's members are subscribers or enrollees as allowed by Rule 1300.69(a)(1), the Plan has not yet implemented these changes.

As part of the Follow-Up Review, the Department will evaluate the organizational chart for the Board of Directors, as well as the individual information sheets for the members

[3] Filing #20140822

of the Board as filed with the Department's Office of Plan Licensing to confirm compliance.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan fails to identify and process all grievances in accord with all the requirements under the law.

Statutory/Regulatory Reference(s): Section 1368(a)(1); Section 1386(b)(1); Rules 1300.68(b)(1) and (5); and Rules 1300.68(d)(1) and (3)

Assessment: Rule 1300.68(a)(1) provides that "'Grievance' means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. *Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance*." [Emphasis added.]

Section 1368(a)(4)(B) provides that grievances received "by telephone, by facsimile, by e-mail, or online … that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day" are exempt from sending the written acknowledgement and resolution letter. However, exempt grievances must be maintained in a log that includes the information specified in Section 1368(a)(4)(B)(i). Otherwise, the Plan must send written acknowledgement and resolution letters under Rules 1300.68(d)(1) and (3) and log the grievance pursuant to Rule 1300.68(d)(8).

The Department found that the Plan resolves grievances in one day, but instead of sending acknowledgement and resolution letters, the Plan simply treats those grievances as an inquiry.

1. **Expressions of dissatisfaction are processed as inquiries rather than grievances**

The Plan's California Grievance Process Standard Operating Procedure, states:

> Inquiry Process - An inquiry is defined as a verbal or written request from a Customer, designee or guardian for general information. Examples of an inquiry include: benefit interpretations, eligibility issues, ID card requests, or confirmation of a co-pay or fee schedule charge.
>
> Complaint & Grievance Process - A complaint or grievance is defined as a verbal or written expression of dissatisfaction from a Customer, designee, Customer's dental provider or guardian on behalf of a Customer.

This procedure cited above requires the Customer Service Associates (CSA) to record calls that are resolved within one day in their database with an "I," which stands for "Inquiry." Other calls, which the CSAs determine are complaints, are forwarded to the National Appeals Unit for review and resolution. Although not required, if all complaints received by the Plan are processed under its standard grievance process, the Plan's policy does not mention a process for "exempt" grievances under Section 1368(a)(4)(B). Rather, the policy only addresses inquiries and standard grievances.

Per the above procedure, Customer Service Associates are trained to include a code in the database for each incoming call. The call is coded with either an "X" for a complaint, or an "I" for an "Inquiry." The "complaints" are faxed or emailed to the National Appeals Unit in California (the grievance and appeals team) where they are reviewed, resolved, and tracked by the grievance and appeals associate.

Pre-onsite review of Plan submitted documents revealed the absence of a log maintaining grievances exempt from the written communication requirements as outlined in Rules 1300.68(d)(1) and (3). Onsite interviews with the Quality Compliance Officer, the Grievance and Appeals Manager, and the Grievance and Appeals Senior Associate, revealed that the Plan does not document or track grievances resolved within one day of receipt by the CSAs. When queried about the Plan's exempt grievance process, the Regional Dental Director stated:

> We call these "one and done." Our customer service reps try to fix these on the phone and they are tracked as an inquiry if member chooses to not file a grievance. Reps are trained to consider these calls as complaints but the member has the choice to file a grievance or not. If it is an issue such as "dirty office" and member does not want to file a grievance, we do a follow up at that provider office for that issue.

However, in the onsite interview, the Dental Director identified an issue such as a "dirty office" not being considered as a grievance but rather as an inquiry if the member does not wish to file a grievance. This classification as an inquiry is not compliant with the requirements of Rule 1300.68(a)(1) which requires that the Plan treat any "written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns" as a grievance.

Rule 1300.68(a)(1) does not allow the Plan to reclassify an expression of dissatisfaction as an inquiry, simply because the member does not wish to file a grievance. Furthermore, a complaint about a "dirty office" should be treated as a potential quality issue (PQI), logged in the PQI Log, investigated, and processed as a standard grievance under Rules 1300.68(d)(1) and (3) or as an exempt grievance under Section 1368(a)(4)(B).

Section 1368(a)(1) requires Plans to maintain a grievance system that provides reasonable procedures that ensure adequate consideration of enrollee grievances and rectification when appropriate. Rule 1300.68(a)(1) defines grievances and states that if a plan cannot distinguish between a grievance and an inquiry, it shall be considered a

grievance. Thus, the Department finds the Plan in violation of these statutory and regulatory requirements.

2. Grievances are misclassified as inquiries and are not maintained in a log; Thus, these grievances cannot be tracked or trended.

The Plan does not track those grievances that are resolved and logged as inquiries in a grievance log as required by Rule 1300.68(b)(5). Thus, they are unable to identify through tracking and trending any emergent patterns of grievances, as required by Rule 1300.68(b)(1). Improper identification of enrollee complaints deprives enrollees from the full grievance and appeals rights and protections afforded to them under the Knox-Keene Act.

During staff interviews, the Department determined that the Plan does not maintain a separate log of the issues received and resolved by customer service, including who took the call and resolved the grievance. It also does not include them in the reporting to the Quality Assurance Committee or the tracking and trending analysis reviewed by the appropriate committees.

While the Department acknowledges the Plan utilizes an electronic database (WEBSTER) to record and track grievances, the Plan is not tracking and trending grievances being inappropriately classified as inquiries. This fact was further demonstrated by the Plan's failure to provide the Department with any type of log of these issues.

Notably, the Department also found that the Plan's grievance record kept pursuant to Rule 1300.68(b)(5) fails to meet all the requirements of the rule. Review of the log fails to include "the plan representative's name who took the call and resolved the grievance."

3. The Plan's Grievance Policy was not approved by the Department.

The Plan's policy, California Grievance Process Standard Operating Procedure, shows multiple revision dates, including January 1, 2009, August 19, 2010, and June 10, 2013, for which the Department can find no evidence of Department approval. However, Section 1368(a)(1) requires "Every plan … Establish and maintain a grievance system *approved by the department* under which enrollees may submit their grievances to the plan." [Emphasis added.]

As the Plan does not record all grievances, send written acknowledgment and resolution letters, and it has not submitted the operational grievance policy to the Department for approval, the Department finds the Plan is not in compliance with Section 1368(a)(1), Section 1386(b)(1), Rules 1300.68(b)(1) and (5) and Rules 1300.68(d)(1) and (3).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's response to this deficiency stated in part:

> **"**Effective 6/1/2015 the Plan will be implementing a process to identify and track expressions of dissatisfaction resolved by a customer service associate on the same day or by the next business day as an exempt grievance as described by Section 1368(a)(4)(B). The Plan will also begin to maintain a log of such grievances for tracking and trending as required by Rule 1300.68(b)(5) and Section 1368(a)(4)(B)(i). Exempt grievances will be tracked in the Plan's WEBSTER call tracking system using a special resolution code that will be unique to exempt grievances. The Plan will monitor these incidents on a daily basis to ensure proper handling by the Customer Service Associates. The Plan will also review the log of exempt grievances at its quarterly Grievance Subcommittee to track and trend these grievances and for possible inclusion in the Plan's PQI log. All other grievances not resolved by the customer service associate on the same day or by the next business day will be handled as a standard grievance."

The Plan also submitted copies of the California Grievance Process Policy and Grievance Subcommittee Policy containing revisions to define the process for the identification of what constitutes an exempt grievance, as well as the process for the receipt and review of grievances identified as exempt. These changes included tracking requirements to include identification and review of exempt grievances for potential quality issues. The Plan also indicated it has revised its internal mechanisms to ensure that its California Grievance Policy will be filed with the Department following any updates.

Final Report Deficiency Status: Not Corrected

The Department finds that while the Plan has initiated actions to correct this deficiency, not enough time has passed for the Plan to prove effectiveness and implementation of the Plan's revised process. The Department will review the Plan's Exempt Grievance Log, tracking reports, Grievance Subcommittee meeting minutes, and will verify the submission of the Plan's revised grievance policy with the Department as part of the Follow-Up Review.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

UTILIZATION MANAGEMENT

Deficiency #4: The Plan does not have a documented quality assurance process that assesses and evaluates compliance with utilization management requirements under Section 1367.01.

Statutory/Regulatory Reference(s): Section 1367.01(j)

Assessment: Pre-onsite review of the Plan's document, Quality Management Program Metrics, Cal, revealed that while the Plan has a robust Quality Management Program when it comes to the actual care provided to members, encompassing among other metrics, access and availability of providers, including appointment scheduling and office wait times, and customer satisfaction, the Plan does not have a quality assurance process in place to assess and evaluate the Plan's internal compliance with utilization management requirements. For example, there was no evidence found to indicate that the Plan monitors timeliness of determinations to ensure decision timelines are consistently met, or that the Plan conducts any monitoring or auditing, such as inter-rater audits, to ensure consistent application of criteria used to make determinations. The Department reviewed the Plan's standard operating procedure for utilization review document, Utilization Review Standard Operating Procedure, which contains the requirements for communicating utilization management decisions, but this document did not reference any monitoring process for ensuring the timeliness of these communications.

During onsite interviews, the Regional Dental Director stated that, to his knowledge the Plan did not conduct monitoring or reporting of its internal utilization management processes, including timeliness of decision-making. The Regional Dental Director also stated that the Plan did not conduct any internal auditing to ensure consistency of application as it relates to its medical necessity criteria.

The Plan's Quality Management Committee Meeting Minutes revealed that while the Plan does evaluate the utilization patterns of its providers, and monitors compliance with provider access and availability standards as applicable to its utilization standards, no evidence that the Plan conducts any monitoring or review of internal utilization management activities or decision making was found by the Department.

California Health and Safety Code section 1367.01(j) states:

> A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

The Department found no evidence that the Plan has any processes in place to assess and evaluate its compliance with the utilization management requirements outlined in Section 1367.01(a)-(i), therefore the Department finds the Plan to be non-compliant with Section 1367.01(j).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan's response stated:

The Plan reported that it previously updated its policy, "Cigna Dental Health of California, Inc. Utilization Management Subcommittee Standard Operating Procedure", to include provisions for meeting this requirement. These changes were implemented on 12/05/2013. The following utilization review items were added for review during the quarterly subcommittee meetings:

- Time to Process: Review of Claims (Specialty Referral) processing data to both assess for timeliness compliance and identify trends and problematic issues. Action plans will be implemented as deemed appropriate.
- Claim Audits: The Plan has implemented an internal audit of claims reviewed by Dental Consultants to ensure consistent application of Clinical guidelines when making claim payment/denial determinations. The internal audit will also ensure that appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others.
- Explanation Of Benefit Review: Review samples of EOBs to ensure that all information is populating appropriately and are produced timely for both customer and dentist for the following claim types:

    - Approval
    - Denial
    - Pended

  All activities from the California utilization subcommittee are reported to the Quality Management Committee.

The Plan submitted a copy of the Cigna Dental Health of California, Inc. Utilization Management Subcommittee Standard Operating Procedure, as well as the Utilization Management Subcommittee meeting minutes for all four quarters of 2014. Review of this the policy confirmed the Plan now has an internal process to ensure consistent application of clinical guidelines.

Previous Department review of the Plan's document, Utilization Review Standard Operating Procedure, revealed that the policy included detailed decision and communication timeframes for requests by providers for health care services, but did not include any monitoring process for ensuring the timeliness of decisions or the timeliness of communications to providers and enrollees regarding the Plan's decisions. Review of the Cigna Dental Health of California, Inc. Utilization Management Subcommittee Standard Operating Procedure did not demonstrate that the Plan had integrated the monitoring process into the revised policy.

The Plan also stated that the Utilization Management Subcommittee was reviewing Explanation of Benefits during the committee's quarterly meetings but review of the submitted meeting minutes did not reveal any discussion or statistics on compliance with the decision or communication timeframes. Review of the Utilization Management Subcommittee meeting minutes showed the committee reviewed the Explanation of Benefits for the following elements:

- Denial Codes and verbiage match?
- Notice of Appeal?
- IMR verbiage
- Dental Consultant contact info (treating dentist EOB only)?
- Overall layout?
- Date of production?

The subcommittee did not validate the timeliness of either the decision-making process, or the communication to the provider and enrollee of the Plan's decision.

Additionally, despite the Plan's statement "All activities from the California utilization subcommittee are reported to the Quality Management Committee," examination of the Quality Management Committee Meeting minutes demonstrated no presentation by the Utilization Subcommittee of any statistical decision or communication timeliness review.

Final Report Deficiency Status: Not Corrected

The Department finds that the Plan still has not demonstrated that the Quality Assurance Program includes a process by which the Plan's compliance with the decision timelines and communication requirements of Section 1367.01(h)(1) through (5) are fully assessed and evaluated. The Utilization Management Subcommittee's review of the Explanation of Benefits does not consider when the original request for services were made by the provider. Absent information of actual dates when the requests were made, the Plan cannot determine if the decisions were made timely, nor if the communications to the provider and the enrollee of the Plan's decision were made in compliance with the requirements of the Act.

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. The Department will conduct a Follow-Up Review of the Plan and issue a Report within 14-16 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2013 Routine Dental Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.